CMD-1014A FORPF (11-07)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Children, Youth and Families
Comprehensive Medical and Dental Program (CMDP)
Eligibility Unit, Site Code 942C
P.O. Box 29202 • Phoenix, AZ 85038-9202

# CMDP ENROLLMENT / APPLICATION FOR MEDICAL ASSISTANCE FUNDING

**COMPLETE ALL SECTIONS • SIGNATURE REQUIRED!**

This application must be completed on behalf of every child in custody who is eligible for CMDP, within 3 days of the child's CMDP eligibility date. **REPORT ALL CHANGES TO CMDP. Be sure to sign the form on page 2.**

## CHILD'S INFORMATION

CHILD'S NAME *(Last, First, M.I.)* | CASE NO.

☐ New Enrollment
☐ Change of

CHILD'S PLACEMENT ADDRESS *(No., Street, City, State, ZIP)*

BIRTHPLACE *(City, State)* | DATE OF BIRTH | SOC. SEC. NO. | AGE | SEX ☐ M ☐ F

ETHNICITY | WHAT LANGUAGE DOES THE CHILD SPEAK? ☐ English ☐ Spanish ☐ Other *(specify)*: | WHAT LANGUAGE DOES THE CHILD READ? ☐ English ☐ Spanish ☐ Other *(specify)*: | CUSTODIAL AGENCY ☐ AOC ☐ DJC ☐ DDD ☐ DCYF

DATE OF MOST RECENT ENTRY INTO FOSTER CARE | TYPE OF PLACEMENT ☐ Foster Home ☐ Group Home ☐ Shelter ☐ Residential Treatment ☐ Relative ☐ Other :

NAME OF PLACEMENT | PHONE NO. *(Include area code)*

PROBATION / PAROLE OFFICER'S NAME *(First, Last)* | PHONE NO. *(Include area code)*

SITE CODE IF DDD/DCYF; OR MAILING ADDRESS IF AOC / DJC

IS THE CHILD PREGNANT
☐ No ☐ Yes If yes, expected date of delivery:

IS THE CHILD A U.S. CITIZEN | ALIEN NO.
☐ No ☐ Yes If no, is the child a **documented** alien ☐ No ☐ Yes

MOTHER'S MAIDEN NAME *(Last, First, M.I.)*
Deceased ☐ No ☐ Yes

FATHER'S NAME *(Last, First, M.I.)*
Deceased ☐ No ☐ Yes

WAS THE CHILD WHO YOU ARE APPLYING FOR ON THIS APPLICATION RELEASED FROM PRISON, JAIL OR THE ARIZONA STATE HOSPITAL THIS MONTH
☐ No ☐ Yes If yes, who: Date of release:

DID THE CHILD MOVE TO ARIZONA THIS MONTH
☐ No ☐ Yes If yes, date moved to Arizona:

## RESOURCES/INCOME

DOES THE CHILD HAVE ANY ASSETS / PROPERTY LISTED BELOW
☐ No ☐ Yes If yes, complete applicable type(s).

| TYPE | FINANCIAL INSTITUTION | ACCOUNT NO. | AMOUNT |
|---|---|---|---|
| Checking Account | | | $ |
| Savings Account | | | $ |
| Trust Fund — DATE AVAILABLE | | | $ |
| Other *(specify)* | | | $ |

IS THE CHILD EMPLOYED?
☐ No ☐ Yes If yes, complete information below.

EMPLOYER'S NAME | CHILD IS EMPLOYED ☐ Full Time ☐ Part Time

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)* | PHONE NO. *(Include area code)*

MONTHLY GROSS INCOME *(Including tips)* | HOW OFTEN PAID ☐ Weekly ☐ Bi-weekly ☐ 2x Monthly ☐ Monthly | HOW VERIFIED

See page 4 for EOE / ADA disclosures.

IS THE CHILD SELF-EMPLOYED?

☐ No ☐ Yes If yes, complete information below.

| TYPE OF BUSINESS | HOURS PER WEEK | MONTHLY GROSS INCOME | MONTHLY EXPENSES | HOW VERIFIED |
|---|---|---|---|---|
| | | | | |

IS THE CHILD A STUDENT REGISTERED IN SCHOOL? HOW VERIFIED?

☐ No ☐ Yes If yes, CHILD is a ☐ Full Time ☐ Part Time Student

DOES THE CHILD OR CUSTODIAL AGENCY RECEIVE ANY OF THE UNEARNED INCOME LISTED BELOW?

☐ No ☐ Yes If yes, complete the applicable type(s).

| TYPE | MONTHLY AMOUNT |
|---|---|
| Child Support | $ |
| VA | $ |
| Social Security | $ |
| Parental Assessment | $ |
| Other *(specify)*: | $ |

IS THE CHILD COVERED BY ANY OTHER HEALTH INSURANCE OTHER THAN AHCCCS?

☐ No ☐ Yes If yes, complete the information below.

DID THE CHILD ON THIS APPLICATION HAVE HEALTH INSURANCE WITHIN THE LAST THREE (3) MONTHS?

☐ No ☐ Yes If yes, complete the information below.

| INSURED PERSON'S NAME | | INSURANCE COMPANY'S NAME | |
|---|---|---|---|
| PHONE NO. *(Include area code)* | POLICY NO. | EFFECTIVE DATE | DATE ENDED |
| | | | |

DOES THE CHILD LISTED ON THIS APPLICATION HAVE ANY UNIQUE CULTURAL NEEDS THAT REQUIRE SPECIAL SERVICES?

☐ No ☐ Yes If yes, specify needs

IS THERE A COURT ORDER FOR A PARENT WHO DOES NOT LIVE IN THE HOME TO PROVIDE MEDICAL SUPPORT, I.E. HEALTH INSURANCE FOR A CHILD?

☐ No ☐ Yes If yes, specify

DOES THE CHILD HAVE A CURRENT INJURY OR ILLNESS BECAUSE OF AN ACCIDENT OR MEDICAL MALPRACTICE?

☐ No ☐ Yes If yes, specify illness

DOES THE CHILD LISTED ON THIS APPLICATION HAVE A CHRONIC ILLNESS MEDICAL CONDITION THAT REQUIRES FREQUENT AND ONGOING TREATMENT AND IF NOT PROPERLY TREATED WILL SERIOUSLY AFFECT THE PERSON'S OVERALL HEALTH?

☐ No ☐ Yes If yes, specify condition

# VERY IMPORTANT - SIGNATURE REQUIRED

**CMDP needs your signature to process your application.**

**Statement of Truth:** I swear under penalty of perjury that the statements made on this application and any other statements that I made *(or will make)* during the application process are true and correct to the best of my knowledge. Photocopies I have provided *(or will provide)* are the same as the original document. I have read and understand all of the information under DECLARATIONS on page 3, including the warning about possible criminal prosecution and penalties for providing false information.

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE

**ORIGINAL SIGNATURE REQUIRED!**

**Direct any questions regarding this application to 602-351-2245 or 1-800-201-1795 and/or PLEASE route completed application to:**

**CMDP Title XIX Eligibility Unit**
**Site Code 942C**
**P.O. Box 29202**
**Phoenix, AZ 85038-9202**

See page 4 for EOE / ADA disclosures.

**KEEP THIS INFORMATION FOR YOUR RECORDS**

# DECLARATIONS

## Cooperation:

I understand that eligibility specialists from DES/CMDP will review my application for AHCCCS medical assistance and will contact me if they need more information.

I agree to:

- Provide all of my information and proof needed to make a decision on this application;
- Identify anyone who may be responsible for my medical care, including but not limited to: health and disability insurance, accident and insurance claims, legal settlements and medical support orders;
- Report when any information that I have provided on this application changes;
- Provide all information and proof to state or federal personnel who are doing a quality control review of the eligibility of any person for whom Medical Assistance is approved; and
- Provide all information and proof to the DES/CMDP Division of Child Support Enforcement (DCSE) to obtain medical support from any parent who is absent from the home. This may require establishing paternity. *(This applies only if you are a parent of a child younger than age 18 who is approved for Medicaid and you are applying for Medicaid for yourself. You may claim good cause for not providing information or proof if you can show that it could result in physical or emotional harm to you or to the child.)*

## HIPAA Authorization to Release Information:

**I agree to the release of personal and financial information from this application, including supplemental forms and supporting information to DES/CMDP for the purpose of determining eligibility for AHCCCS medical assistance.**

**If I authorize:**

- The eligibility agency to contact any sources needed to verify my information needed to determine eligibility for AHCCCS medical assistance;
- The release of information from any source having information, including protected health information that is included on my financial billing records, when needed to determine eligibility for AHCCCS medical assistance;
- The release of information by DES or CMDP or its agents to an agency hired to pay my medical bills; and
- The release of information to DES/Division of Child Support Enforcement (DCSE), if I am the parent of a child who does not live with the child and has AHCCCS medical assistance. DCSE may use this information to get a medical support order; and

**I understand that:**

- I have the right to revoke this authorization at any time by sending a written notice of revocation to DES/CMDP. This authorization will be revoked when DES/CMDP receives the written revocation, but the revocation will not apply to information that has already been released in response to this authorization.
- Unless revoked earlier, this authorization will expire when the application for assistance through DES/CMDP is withdrawn or denied, or when eligibility for assistance through AHCCCS medical assistance ends.
- This authorization will continue during any time while I as a member is contesting eligibility in an administrative hearing or court proceeding.

## Assignment of Rights to Other Benefits for Medical Care:

If the child is approved for AHCCCS medical assistance, DES/CMDP can collect payment from any other parties who may be responsible for paying for our health care costs. This includes:

- Private or employer-sponsored health insurance *(not including Medicare)*
- Persons, such as an absent spouse or parent, who are legally responsible for providing medical support
- Private or employer-sponsored disability insurance
- Private or employer-sponsored accident insurance
- Insurance claims, jury awards, or legal settlements resulting from injuries, I understand that DES/CMDP cannot collect more than the costs paid.

I also understand that I must give information about other responsible parties and take any action needed to receive medical support. This includes establishing paternity of my children, unless I can prove good cause not to do so.

Equal Opportunity Employer/Program ◆ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact (602) 351-2245 or 1-800-201-1795; TTY/TDD Services: 7-1-1.